STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	003258	A. BUILDING: _____ B. WING _____	C 10/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSONAL TOUCH HOME CARE OF INDIANA INC	139 W TATE ST STE 1 LAWRENCEBURG, IN 47025

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	Initial Comments This was a state complaint investigation for an ACHC deemed home health agency Complaint # IN00150132 - Unsubstantiated: Lack of sufficient evidence. Survey Dates: October 24, 2014 Facility #: 003258 Medicaid #: 200409440 Surveyor: Nina Koch, RN, PHNS Personal Touch Home Healthcare was found to be in compliance with 410 IAC Article 17, Rule 12 section 1(m) and 3 and Rule 14 Section 1 as related to this complaint. Quallity Review: Joyce Elder, MSN, BSN, RN October 31, 2014 n	N 000		